

NORTH CAROLINA MEDICAID

Neupogen Prior Authorization

Request Date _____

Recipient's Medicaid ID# _____ Date of Birth ____/____/____

Recipient's Full Name _____

Prescriber Full Name _____ Prescriber DEA # _____

Prescriber Address (mandatory) _____

City _____ State _____ Zip _____

Prescriber Telephone # _____ Prescriber Fax # _____

Prescriber E-mail Address _____

Drug Strength / NDC (If available) submitted on claim _____

1. What is the diagnosis or indication for the product? Please check below.
☐ Cancer patients receiving myelosuppressive chemotherapy
☐ Cancer patients receiving bone marrow transplant
☐ Acute Myeloid Leukemia receiving induction or consolidated chemotherapy
☐ Peripheral blood progenitor cell collection and therapy in cancer patient
☐ congenital ☐ cyclic ☐ idiopathic Severe Chronic Neutropenia
☐ Severe neutropenia in AIDS patients on antiretroviral therapy
2. Is this New Therapy (☐) or Continuation of Therapy (☐)?
3. Lab Test Date (Dated within the last 3 months): _____
Absolute Neutrophil Count: _____ cells/mm³
4. What is the date range of therapy?
Begin Date: _____ End Date: _____
5. What is the dosage and frequency of dosing? _____

Instructions to submit: (Choose one)

To Fax or Mail:

1. Form may be completed electronically or handwritten.
2. Fax or mail to ACS State Healthcare.

To Email:

1. Save the form using a different filename.
2. Complete electronically.
3. Email as an attachment to ACS State Healthcare.

Send ACS State Healthcare, Prescription Benefits Management

to: Prior Authorization Dept.
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30350

Fax: (866) 246-8507

Phone: (866) 246-8505; M-F 7am-11pm, EST; S-S 7am-6pm, EST

E-mail: nc.providerrelations@acs-inc.com

FOR AFFILIATED COMPUTER SERVICES (ACS) USE ONLY

Date: _____ Notified: _____

Approved: _____ Denied: _____

Reason: _____